EXHIBIT A

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Stephanie H. Taylor, MD.	)	
a/k/a Stephanie Taylor Tasi, MD	)	Docket Nos. MPS 45-0304
	)	MPS 48-0304

AFFIDAVIT OF PHILIP J. CIOTTI

COMES NOW Affiant, Philip J. Ciotti, investigator, Vermont Board of Medical Practice, and, under penalties of perjury, does depose and state as follows:

1. I am an investigator for the Vermont Board of Medical Practice. I am responsible as Board investigator for gathering information, evidence, and testimony regarding complaints and allegations against practitioners in the field of medicine who may have engaged in unprofessional conduct.

2. I am familiar with the above-captioned matters involving Respondent, Stephanie H. Taylor, M.D. Dr. Taylor holds Vermont medical license No. 042-0008406, which was issued by the Board on September 9, 1991. Between 1991 and 1995, Dr. Taylor practiced as a psychiatrist in Stowe.

3. In 1995 the Vermont Board of Medical Practice summarily suspended Dr. Taylor's medical license following suspension of her privileges by Copley Hospital in Morrisville. In 1996, Dr. Taylor signed a stipulation and consent order with the Board, admitting to having engaged in unprofessional conduct, admitted to "chemical impairment" placing her patients at risk and to mental impairment affecting her competency to render medical care to patients. Complaints to the Board also alleged, according to the stipulation, "egregious professional boundary violations", an incident of sexual misconduct with a patient, and misprescribing or dispensing controlled substances. Dr. Taylor admitted to having disregarded fundamental principles governing doctor-patient boundaries in her practice. The

stipulation and consent order identified a series of reinstatement requirements, including a prohibition against any future practice by Dr. Taylor as a psychiatrist.

4. Between 1995 and 2000, Dr. Taylor did not practice medicine. Her medical license was in suspended status during this period. Her license also lapsed, and became invalid for practice in Vermont on November 30, 1996.[1] In June 2000, the Board approved an amendment of Dr. Taylor's stipulation and consent order to allow her to retrain in a family practice residency at Tufts University in Massachusetts. The agreement required Dr. Taylor to practice solely in Massachusetts, to practice only in a structured group setting, and to practice medicine only as required by the family practice residency.

5. On February 18, 2004, the Massachusetts Board of Registration in Medicine suspended Respondent Taylor's medical license. The Vermont Board subsequently learned of this suspension and opened Docket No. MPS 48-0304 for investigation. According to available documentation, the suspension of Respondent's medical license in Massachusetts was based on a finding by the Massachusetts Board that Respondent was not in compliance there with her terms and conditions of licensure. Dr. Taylor had stopped providing urine samples for monitoring as required by her agreement with the Massachusetts Board. She had not arranged with the Massachusetts Board "transfer" of her monitoring obligations to Vermont and had not finalized agreement on a contract with the Vermont Physicians Health Program. Dr. Taylor was informed in writing of the possible suspension of her medical license and told that she could request a hearing to contest her alleged non-compliance with terms of her agreement with the Massachusetts Board. She failed to do so.

6. Dr. Taylor did not notify the Vermont Board of Medical Practice that her medical license

1. Dr. Taylor's Vermont medical license was not reinstated until May 21, 2003, meaning that she could not legally practice in

had been suspended in Massachusetts for non-compliance with her probation requirements. Board rules require that such an action be reported.

7. In early 2003, as Respondent was nearing completion of a three-year residency in family practice at Tufts University, the Vermont Board amended Respondent's Stipulation and Consent Order in April 2003, entering new terms and conditions permitting her to practice medicine in Vermont, but only in a structured group setting. Dr. Taylor also was required to be referred to and to follow all reasonable recommendations of the Vermont Practitioner Health Program, to continue to abstain from drugs and alcohol, and not to prescribe for herself or family members.

8. A second complaint against Dr. Taylor, Docket No. MPS 48-0304, was opened by the Vermont Board of Medical Practice on or about April 1, 2004 following receipt of a written complaint from an individual ("Patient B") who alleged substandard care had been provided to him by Dr. Taylor and alleged she had improperly disclosed confidential medical information about him to a third party.

9. Patient B sometimes traveled to Massachusetts to visit with Dr. Taylor. In Patient B's written complaint, supplemented by a phone interview with me, Patient B indicated that he had experienced some medical problems beginning around September 2002. Patient B stated that while in Vermont he called Respondent Taylor in Massachusetts and described to her his symptoms. Dr. Taylor stated that she believed that Patient B had a urinary tract infection. She then phoned in a prescription to Copley Hospital for Doxycycline and other drugs. Patient B was to pick this medication at the hospital because area pharmacies were then closed for the day.

10. Patient B went to Copley Hospital in Morrisville to get his prescription. Patient B told me the prescription seemed at first to work but then the "infection came back with a vengeance". Patient B was not physically examined by Respondent prior to her prescribing for him. Nor was Patient B

otherwise examined at the hospital. The patient said that Dr. Taylor had provided him with prescriptions in both Vermont and Massachusetts. Patient B felt these had not been helpful to his condition.

11. According to Patient B, Respondent provided him with prescriptions for Lexapro, Vioxx, and Oxycodone. Patient B claimed that on one occasion he and Respondent Taylor were in Malden, Massachusetts together, and Dr. Taylor prescribed drugs using her own medical insurance for. She picked up the drugs from a pharmacy, peeled off the label on the container, and then gave the drugs to Patient B. The purpose for this, according to Patient B, was to save him money because Patient B had no insurance coverage. Patient B began seeing other doctors in Massachusetts and Vermont because his symptoms were worsening. After being examined and having tests performed, Patient B was diagnosed with prostatitis. Patient B emphasized that at no time had he been physically examined by Respondent Taylor in relation to his medical complaint.

12. At Copley Hospital I obtained records that indicated that Patient B had been at the hospital's emergency room on September 11, 2002 at 10:53 p.m. According to the written record, a phone order had been called in by "Stephanie Taylor- MASS" for Doxycycline capsules and Zithromax capsules. These medications were dispensed to Patient B per Dr. Taylor's order.

13. I spoke with a Dr. Kaeding of Copley Hospital emergency department. He advised that since an out-of-state physician had called in the medications for Patient B, and considering the nature of the medications, the phone ordered prescription was dispensed as a professional courtesy.

14. I went to Heritage Drugs in Stowe. I wanted to see if Dr. Taylor had engaged in any other medical practice activities in Vermont. Her Stipulation and Consent Order with the Board required that she practice only in Massachusetts, and only if such practice was directly related to her Tufts residency. She also was required to provide all medical care only in a structured group setting.

At Heritage drugs I obtained records that identified Dr. Taylor as the prescribing physician for the following prescriptions:

For Patient B

9/12/02 Cipro 500MG

9/12/02 Doxycycline 100MG

9/12/02 Phenazopyridine 200MG

For Patient C

9/04/02 Lipitor 20MG

10/28/02 Lipitor 20MG

11/30/02 Meclizine 25MG

1/08/03 Clonazepam .5MG

3/08/03 Clotrimazole/Betameth

3/08/03 Metoclopramide 10MG

3/11/03 Zocor 20MG

3/11/03 Celebrex 200MG

3/12/03 Flonase .05%

3/12/03 Amoxicillin 875MG

4/21/03 Celebrex 200MG

4/21/03 Zocor 10MG

4/21/03 Allegra 60MG

4/21/03 Oxycodone w/APAP 5/325

For Patient D

6/04/2003 Estring 2MG

Patient D (continued)

7/19/2003 Estring 2MG

All these prescriptions were order by Dr. Taylor during the period when, at a minimum, she was required to practice only in a structured group setting. Until April 2, 2003 Respondent Taylor also was restricted to practice only in her family practice residency at Tufts University and only in Massachusetts. Dr. Taylor's Vermont medical license was "lapsed" and therefore invalid for practice in Vermont until May 21, 2003 when it was reinstated by the Board.

15. On March 30, 2004, I interviewed a female, out-of-state witness by telephone. The witness told me the following:

> [Patient B] and I were going together from approx. 2000-2002. He lived in Vermont but lived part of the year down here in Florida. I knew Stephanie Taylor because of their relationship. She and I had met before, and she was cordial to me. There were times however, when she and [Patient B] were at each other's throats. There came a time when [Patient B] and I were beginning to drift apart and I actually began having some phone conversations with Stephanie. We were sort of friendly and called each other a number of times. I was trying to get some insight out of her about [Patient B].
>
> Around mid 2002, I had a phone conversation with Stephanie and she told me that I should probably stay away from [Patient B]. The way she said it made me ask why. She acted reluctant to tell me but then said that [Patient B] had recently been seeing another woman and then developed a health problem. I asked what it was and she said it might be Chlamydia or some other form of STD.

Stephanie said she prescribed him something for it in Boston. She said he was having "burning urination". I didn't know at the time that he had been cheating on me and so I confronted him and he admitted it. We then broke up, although I think we would have broken up regardless.

16. I spoke with Attorney Peter Anderson who is representing the Respondent in a proceeding . The basis was due to . Attorney Anderson told me that Patient B's complaint to the Board was harassment and retaliation against Dr. Taylor. The attorney told me that Respondent Taylor did not write Patient B any narcotics prescriptions. Attorney Anderson told me that

17. On April 5, 2004, the Board received a written response from Respondent addressing the written complaint filed by Patient B. Respondent stated the following:

From July 1st 2000 though June 30th 2003 I was doing a Family Practice Residency through Tufts University in MA. On September 9th 2002 Patient B had me paged through the residency clinic telling the operator that it was an emergency. His emergency was that he had a stinging sensation in his penis. I suggested that he get a urine culture. He told me that he had already taken some antibiotics from the medicine cabinet of the lady he was house sitting for. I told him that the medication would invalidate any urine culture. He said he didn't know what might have caused these symptoms.

Two days later he called again saying he felt much worse. I asked again if he had any thoughts about the cause. He then told me he had unprotected sex on September 8th with a stranger that he met in a bar. I told him to go to Copley Hospital ER to get treatment for a sexually transmitted disease. He went to Copley and got the usual

antibiotic regimen. His symptoms improved but did not disappear. He moved to his parent's house in MA and was panicked about his symptoms and called me daily. I referred him to Dr. Tierny, "a good Urologist in MA." and he also saw Dr. Butler, a colleague of Dr. Tierny. Dr. Butler is an Infectious Disease Specialist and the head of the community hospital where I worked as a resident. When we were on call we were responsible for phone calls which came in after hours or on weekends. Patient B called Dr. Butler one day and said he needed more antibiotics. Dr. Butler paged me and asked me to take care of it since he was on his way out the door. I explained that I did not want to write a prescription . Dr. Butler pointed out that Patient B and that he would thoroughly document that he had requested that I call in the prescription.

At one point after Patient B had been diagnosed with a prostate problem, he asked if I would do daily rectal exams and prostatic massage on him. I told him his request was completely inappropriate. He suggested that he could just be patient #449 and totally impersonal. I pointed out that I was NOT his doctor.

After becoming engaged to Patient C, Patient B filed this complaint with very distorted facts. This falls in the category of harassment and nothing more or less.

18. In the Respondent's written response she expressly claimed her unwillingness as to "writing [a prescription] for a family member". However, she did not explain or acknowledge that, in fact, she had phoned in a prescription when she suggested that Patient B go to Copley Hospital here in Vermont. Respondent also failed to address in her written response Patient B's allegation that she

breached medical confidentially by telling Patient B's girlfriend that he might have contracted a sexually transmitted disease from a stranger.

19. On April 13, 2004 I again spoke to Patient B on the phone I asked if he knew Patient D. He told me that Patient D

20. On May 3, 2004, I received a copy of a written response from Dr. Taylor addressed to Investigator Jon Spinale of the Massachusetts Board of Registration in Medicine. The Massachusetts Board also had opened a complaint paralleling the Vermont Board complaint. Respondent said in her response to the Massachusetts Board that Patient B did not have health insurance, and he had asked her if she would call in medication in his brother's name. Respondent advised, "I told him he was crazy to suggest that I commit insurance fraud, etc." 21. On May 5, 2004, I was present at a hearing of the Vermont Board of Medical Practice in Montpelier. This hearing was to decide a motion from the State seeking suspension of Dr. Taylor based the fact that she had had her medical license suspended in Massachusetts. During this hearing Patient C

). Also during this hearing, Respondent Taylor at one point was being questioned by Assistant Attorney General James Arisman. He asked Dr. Taylor to explain her understanding of her present Conditioned License in Vermont. Respondent then explained to the Board that she knew she was not to consume mind altering substances, commit illegal acts, or practice psychiatry. She added that she also was to comply with her monitoring program through VPHP and confine her practice to what was her residency program in Massachusetts and not to practice in Vermont until she was approved for practice in a structured group setting.

22. I began a search of pharmacies in the area adjacent to Tufts University to review Dr. Taylor's prescribing practices in Massachusetts. By telephone, and with the additional assistance of Investigator Jon Spinale of the Massachusetts Board of Registration in Medicine, I found a prescription ordered on 04/04/2003 (and refilled on 06/06/2003) for Patient A for Vioxx 25 mg. Tablets that were dispensed at the Walgreen's Pharmacy in Stoughton, Massachusetts. These prescriptions were ordered by Respondent Taylor according to the pharmacy records. Also, at the CVS Pharmacy in Stoughton, Massachusetts on 11/05/2002 there was a prescription ordered by Dr. Taylor for Patient B for Lexapro 10 mg. tablets. According to information from Merck & Co. Inc., the manufacturer of Vioxx, I noted that it states Vioxx's "safety and effectiveness in pediatric patients below the age of 18 years has not been evaluated."

23. I also noted in a Pharmacy Report from Kinney Drugs in Morrisville, Vermont that Patient B also had received prescriptions for Vioxx from Dr. Patrick Keith of Stowe, Vermont on 07/14/2003, 08/14/2003, 09/13/2003, 10/14/2003, 11/14/2003, and 01/15/2004.

24. In reviewing records from Walgreen's Pharmacy in Stoughton Massachusetts, I also found a prescription ordered on or about 10/18/2002 for Patient B for Oxycodone/APAP 5mg-325 mg. tablets by Respondent Taylor and a prescription ordered written on 10/18/2002 for Patient B for Hydrocortisone 2.5% ointment written by Respondent Taylor.

25. In the same Walgreen's records I found there were also several prescriptions for controlled substances that had been ordered for Patient C whose address

I These prescriptions, ordered by Dr. Taylor, were as follows:

08/30/2002	Clonazapam .5mg	ordered by S. Taylor
12/23/2002	Oxycodone/APAP 5mg-325mg	ordered by D. Begos
02/19/2003	Hydrocodone/APAP 7.5mg-750mg	ordered by S. Taylor
02/20/2003	Tussionex Suspension	ordered by S. Taylor
03/26/2003	Oxycodone/APAP 5mg-325mg	ordered by S. Taylor
04/07/2003	Oxycodone/APAP 5mg-325mg	ordered by S. Taylor

26. On May 28th, 2004 I spoke on the phone with Dr. Theodore Butler, Sr. Vice President of Medical Affairs and Clinical Professor of Medicine at Tufts, in Boston, Massachusetts. I identified myself and told him that I had a faxed a release from a patient to his facility and asked if I could learn from him the circumstances surrounding the treatment of the patient. Dr. Butler asked me the name, and I told him the name of Patient B. He asked for the spelling and initially didn't recognize the name. He told me he would check his files. When he came back to the phone he exclaimed, "Indeed, yes, Patient B, (by name)"! Dr. Butler told me that Patient B had been

and he advised, yes it was. I asked if he realized t

He advised that yes, he seemed to recall that had been the case. He told me that Dr. Taylor accompanied Patient B to the office visit but was not present during his actual exam. I informed Dr.

Butler that the Respondent had notified us that she had also referred Patient B to Dr. Peter Tierney, an Urologist in the area and asked if that was correct. Dr. Butler advised that it was he that referred Patient B to Dr. Peter Tiffany, an area Urologist. He stated that he did not believe there actually was a Dr. Peter Tierney and observed that Dr. Taylor must have been confused. Dr. Butler subsequently sent records to me of the one office visit that he actually had with Patient B on November 1, 2002.

27. Upon review of the office visit note, I called Dr. Butler and inquired about particulars of the record. Dr. Butler explained that for a short period of time, Patient B was a patient of his in Massachusetts. There was only the one office visit and several phone calls. Dr. Butler had conducted an exam and then prescribed a regimen to treat Patient B's urological symptoms as well as Klonopin for anxiety. I read to him the content written by Dr. Taylor in her response, specifically having to do with her explanation for writing Patient B prescriptions. I read the part about Patient B calling Dr. Butler for a prescription and how he, Dr. Butler, was leaving and had asked Dr. Taylor to fill in for him by prescribing for Patient B. I read that Dr. Taylor had stated that she had concerns about writing for a family member and that Dr. Butler purportedly assured her that it was OK and that Patient B was not a family member and that he, Dr. Butler, would thoroughly document this point in the chart. Dr. Butler told me he had no recollection of this ever happening.

28. On June 14th 2004 I met with Respondent Taylor and her counsel Peter Anderson, Esq. at his office in Stowe. The purpose was to conduct a taped interview to inquire into the complaint by Patient B and subsequent findings from my investigation to date. Upon inquiry, Respondent Taylor explained that during July 1, 2000 through June 30, 2003 she worked solely in a residency program at Tufts University and that all patient records would be on file at the various

facilities in Massachusetts associated with that program. Respondent Taylor stated that she kept no records in Vermont and had not engaged in any practice activities in Vermont, including prescribing any medications in Vermont. For the first year of residency Respondent Taylor lived on campus at 100 Hospital Rd., Malden, Massachusetts and later in an apartment at 500 Broadway, in Malden, Massachusetts. While living in Massachusetts, Dr. Taylor stated that she lived

She advised that although she was

29. At times, Patient C would come to Massachusetts for visits with her and at times she would go to Vermont.

30. Respondent advised she remembered "very, very clearly" that she got a page through her clinic at Lawrence Memorial Hospital in MA. on or about September 12 or 13, 2002. It was Patient B complaining of painful urination. Respondent told Patient B to go get a urine culture, get on antibiotics and that he might have a urinary tract infection.

31. Patient B called back again about three days later with apparently worse symptoms, and Dr. Taylor told him to go and be seen at Copley because it sounded like it had moved into a kidney infection. She then was given more information from Patient B about a recent interlude of unprotected sex with someone he met in a bar. Respondent then suspected a possible sexually transmitted disease, and again said, "you better get to Copley". Patient B asked her to call Copley and tell them he was

coming in. Respondent called Copley and said that Patient B was coming in; he had unprotected sex, had systemic symptoms and needs the "standard treatment".

32. I showed the copy of the Copley ER report to Respondent and asked her to examine it. Respondent read aloud that the document and its notation, "phone order" with her name. She denied that she called in a phone order and stated that she "can't do that, call another physician in another state and say DO THIS". I asked if this might have been something that the Copley physician might have done as a courtesy to an out-of-state physician for their patient. Respondent advised that she could not answer that but it was not a policy she had ever seen followed and that Patient B had never been her patient. Respondent advised she simply called to "break the ice" but expected the Copley doctors would do a complete workup. Respondent advised that Patient B was not a patient at any of the Tufts affiliates at the time but did become one later as she had recommended he see Dr. Butler, an expert in infectious disease.

33. Respondent advised that she later "directed Patient B to Dr. Butler's suite" but did not go with him to the appointment. Respondent advised that Patient B saw Dr. Butler twice and also spoke to him on the phone several times.

34. I showed the notes from Dr. Butler to Respondent regarding his treatment of Patient B. Respondent took exception to the written note that "he has been placed on a variety of antibiotics as his [illegible]." Respondent disagreed with the characterization, and said that Patient B had NOT been under her care. Respondent stated that she and Patient B actually had an argument about his care and that told him that she would and could not treat him.

35. I questioned Respondent about her apparent writing of prescriptions for Patient B. Respondent advised that the only time she wrote a prescription was under the order from Dr. Butler, when she was covering for him. Respondent stated that she explained that Patient B was

but that Dr. Butler disagreed with her statement.

36. In follow-up questions regarding the chart for Patient B, I did not find any mention of this purported conversation or any record of any prescription by Dr. Butler for Patient B that would correlate with the prescription that Respondent Taylor had written for Patient B. However, I did find a prescription ordered prior to Patient B's only visit with Dr. Butler. This was for Lexapro and according to pharmacy records was called in by Stephanie Taylor, M.D., on 11/05/2002. There is no record in Patient B's chart from Hallmark to show that Lexapro was prescribed as part of his treatment there or that Respondent Taylor had any reason to order it for Patient B as part of her family practice residency.

37. Respondent Taylor advised, "I can flatly, completely, and convincingly tell you I was not calling in prescriptions for Patient B." Respondent Taylor denied writing or calling in any of the prescriptions predating the visit with Dr. Butler. Respondent Taylor also insisted that Patient B saw Dr. Butler twice and not once as documented in the chart. I again asked if Respondent Taylor ever actually went with Patient B to his visits with Dr. Butler. She said no. When I then pressed as to how she could know that he was seen twice, Respondent became somewhat flustered and said "I don't know. I am doing the best I can. You are asking me to hypothesize."

38. I showed the computer-generated printout for the Vioxx prescriptions written to Patient A and asked Dr. Taylor to explain them. Respondent stated that she did not write these prescriptions and that Patient A was not on Vioxx. Respondent expressly denied writing these for Patient A and denied

providing the drugs to Patient B, so as to save Patient B the cost of the medications by these being put under her medical insurance. Respondent alleged that "[Patient B] had called in these prescriptions under [Patient A's] name, it was not my doing."

39. On another subject, Respondent advised me that Patient B and his girlfriend in Florida had broken up. However, the girlfriend and Respondent had become friends. Patient B was NOT her patient, and although she did not tell the girlfriend about Patient B's medical problems, she DID answer her questions. Respondent advised that even if she HAD told the girlfriend something about Patient B's medical problems, this would not have been a breach because Patient B was not a patient of HERS. Respondent Taylor advised that at one point the girlfriend asked general questions about how a man could get a urinary tract infection. Dr. Taylor listed several ways, including having unprotected sex. Under questioning Respondent admitted that she did tell the girlfriend something about Patient B having met someone at a local restaurant and having unprotected sex with her. Dr. Taylor said she disclosed this information only after the girlfriend had already confronted Patient B and knew the details from him. Dr. Taylor said she then told the girlfriend to "take precautions."

40. I showed Respondent Taylor the prescription written by her for Patient C on 04/21/03 for Oxycodone. Respondent advised that she wrote this prescription under the "auspices of Dennis Begos, MD". She advised that this was coverage for Dr. Begos after Patient C had several esophageal dilatations. I asked if she had any concerns about writing this prescription to an individual who arguably and considering that the drug is a Schedule II narcotic. Respondent advised that Patient C was but he was first and foremost a patient of mine". Upon further inquiry, Respondent did confirm that she was

time of her prescribing for him. I asked if she made Dr. Begos aware of this when she was purportedly requested to write this prescription. Respondent was not sure if she told Dr. Begos or Dr. Begos's nurse but that she informed someone and was still asked to write the prescription. In addition, Respondent advised that she also did a pre-op physical for Patient C upon the "insistence" of her supervisors even though

41. I showed Respondent the computer report of a prescription to ordered for Patient C for Clonazepam which, according to the record, she wrote on 08/30/2002 at Walgreen's, in Massachusetts. Respondent stated that she did not write this and furthermore, that Patient C was not on Clonazepam.

42. I showed Respondent the computer report of a prescription for Patient C for Hydrocodone which, according to the record, she wrote on 02/19/2003. Respondent stated she did not recall writing it.

43. I showed Respondent another computer generated listing showing prescriptions to Patient C for Tussionex Suspension 02/20/2003, Oxycodone 03/26/2003, and Oxycodone 04/07/2003 which, according to the record, she wrote. Respondent stated she did not recall writing any of them.

44. I showed Respondent the complete list of prescriptions ordered in her name at from Heritage Drugs in Stowe. This list showed the various prescriptions ordered by Respondent for Patient C. They were, Lipitor, Meclizine, Clonazepam, Clotrimazole/Betameth, Metoclopramide, Zocor, Celebrex, Flonase, Amoxicillin, Allegra, and Oxycodone. Respondent stated "some of these were legitimately written by me like the Lipitor as well as the Meclizine." Respondent denied writing Klonopin,

(Clonazepam). Respondent stated that anything she did write would have been as coverage for medical treatment at Tufts and most likely for Poul LaPlante, M.D., who was Patient C's primary care physician.

45. I showed Respondent the last name on the report from Heritage Pharmacy. This report showed Respondent as the prescribing physican for Estring for Patient D. Respondent stated that Patient D was not a patient at Tufts but was :. Respondent told me that she had told Patient D that Estring might be something she might want to try. Respondent said she did not prescribe this drug for Patient D. Respondent stated that Patient D had another doctor as her personal physician. Respondent advised that the report of her being the prescribing physician was "interesting" but that she did not prescribe it. In conclusion, Respondent told me that the only prescriptions she wrote either in Vermont or Massachusetts were as the result of her practice as a resident through Tufts.

46. Upon completion of the interview with Dr. Taylor, I called Patient D in Stowe and got her answering machine. I did not leave a message. I continued calling periodically through the afternoon. At 4:30 p.m. I called again and a person answered and identified herself to me as Patient D. I identified myself by name and as an Investigator for the Board of Medical Practice. I asked Patient D if she had spoken to Dr. Taylor today. She said "Stephanie? No I've just walked in the door, what's this about?" I told her that her name came up on a list from Heritage Pharmacy as being prescribed a medication by Dr. Taylor. I asked her to tell me about the circumstances. At first she didn't recall and asked me what the medication was. I told her it was Estring. Patient D advised, "Oh yes, well I had a problem that I was not comfortable discussing with my physician because it was embarrassing." Patient D went on to say that she spoke to "Stephanie" about the problem because she was comfortable doing that. And so Stephanie called in a prescription for her as a favor. I asked if the conversation was in person or over the

phone. Patient D could not recall. I asked if there was any type of physical exam and Patient D sounded surprised exclaiming "no we've just been friends for many years and she knows me."

47. I went to Heritage Pharmacy to examine all of the prescriptions issued there under the prescribing physician name of Dr. Stephanie Taylor. I saw the order for Estring which was a phoned-in order for Patient D. The pharmacist who filled the prescription could not say for sure that he recognized the voice of Dr. Taylor. He told me that if there is ever a question of authenticity he might ask the physician for their DEA number but that phone orders are routinely filled without the number, depending on the type of medication.

48. In checking the prescription records, I saw that the one time a DEA number was asked for on the telephone, it was provided. This was on a prescription to Patient B for Cipro and Doxycycline. On other prescriptions, Dr. Taylor's Massachusetts telephone number was entered. I did recover three handwritten prescriptions on Hallmark Health Center Family Practice prescription forms. These written prescriptions were as follows:

Patient C	03/07/2003	Lotrizone Cream
Patient C	03/07/2003	Metaclopramide
Patient C	04/21/2003	Oxycodone

All three of these prescriptions bear the signature of Stephanie Taylor and appear to be consistent with known examples of Dr. Taylor's' signature on file at the Board of Medical Practice.

49. I called Patient B on the phone. I asked him if he ever saw Respondent Taylor call in any of the prescriptions. He told me he was present at times and actually saw her call in some from her cell phone and some from the Hospital in Massachusetts. I asked him again about the prescription that he thought she had "self-prescribed" to save him money by putting it on her insurance. I told him there was a Vioxx prescription written at the time in the name of Patient A. I asked if that could have been it. He told me it might have but he couldn't recall the exact medication involved. He told me that on one occasion he sat out in the car with , and Dr. Taylor went into the pharmacy herself and got the prescription. When she came out she was peeling off the label. He recalled her saying, "Don't ever report me", and handed him the bottle with medications.

50. Through subpoena, in cooperation with Investigator Jon Spinale of the Massachusetts Board of Registration in Medicine, I obtained a complete record of Patient C's treatments on file with the Hallmark Health System in MA. I examined these records and attempted to match up Patient C's treatments with any and all of the prescriptions I found either in Massachusetts or Vermont that had been ordered by Dr. Taylor.

51. On 11/22/02 Patient C had a Lower Endoscopy performed at Lawrence Memorial Hospital in Medford, Massachusetts by a Dr. Muggia. At the time Patient C listed his next of kin as his brother. Patient C listed his address was listed as a person for whom the Hospital should contact in case of an emergency. In addition, Patient C was listed as being There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

52. On 12/13/02 Patient C had an Endo Colonoscopy performed at Lawrence Memorial Hospital in Medford, Massachusetts, again by Dr. Muggia. Patient C listed his next of kin . Patient C again listed his address as was listed as a person for whom the Hospital should contact in case of an emergency. Patient C was again listed as being . There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

53. On 12/19/02 Patient C had an Esophageal Manometry procedure performed at Lawrence Memorial Hospital in Medford, Massachusetts by Dr. Dennis Begos. Patient C again listed his next of kin . Patient C again listed his address as was listed as a person for whom the Hospital should contact in case of an emergency. Patient C was again listed as being There was no mention in the record of Respondent Taylor having any role in Patient C's medical treatment. (Stephanie Taylor was mentioned in passing in the history and physical by Dr. Begos as being engaged to Patient C.)

54. On 22/23/2002 Patient C had a Laparoscopic Nissen Fundoplication procedure performed at Lawrence Memorial Hospital in Medford, Massachusetts by Dr. Dennis Begos. Patient C again listed his next of kin Patient C again listed his address as , was listed as a person for whom the Hospital should contact in case of an emergency. Patient C was again listed as being Stephanie Taylor was merely mentioned in the history and physical as recorded by Dr. Begos as

being engaged to Patient C. Dr. Taylor was identified on the Interoperative Record as follows: "AUTHORIZED OBSERVER OK'ED PER DR. BUTLER". There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

55. On 01/27/2003 Patient C had a RAD/Barium Swallow performed at Lawrence Memorial Hospital in Medford, MA. There was no mention in the record of Respondent Taylor having any role in Patient C's medical treatment.

56. On 2/07/2003 Patient C had a Gastroendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford by a Dr. Michaelson. Patient C again listed his next of kin as . Patient C again listed his address as . was listed as a person for whom the Hospital should contact in case of an emergency. Patient C was again listed as being . There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

57. On 3/21/2003 Patient C had a Rad/Esophagogram performed at Lawrence Memorial Hospital in Medford. There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

58. On 4/07/2003 Patient C had a Gastroendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford by Dr. Michaelson. Patient C again listed his next of kin as . Patient C again listed his address as . was listed as a person whom the Hospital should contact in case of an emergency. Patient C was again listed as being . There was no mention in

the record of Respondent Taylor having any authorized role in Patient C's medical treatment. On this same date, Respondent Taylor ordered a prescription for Patient C for Oxycodone with APAP, (Percocet). There is no mention of this prescription having been ordered in the Hallmark Health records for this procedure.

59. On 6/06/2003 Patient C had a Gastroendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford by Dr. Michaelson. Patient C again listed his next of kin as Patient C again listed his address as listed as a person whom the Hospital should contact in case of an emergency. Patient C was again listed as being . There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

60. On 10/02/2003 Patient C had a Gastroendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford by Dr. Michaelson. Patient C again listed his next of kin . Patient C again listed his address as was listed as a person whom the Hospital should contact in case of an emergency. Patient C was again listed as being . There was no mention in the record of Respondent Taylor having any authorized role in Patient C's medical treatment.

61. In examining these records I found where only ONE prescription written by Respondent Taylor to Patient C matched up by date (4/7/03) to recorded procedures or treatments provided by Hallmark Health. That was a prescription for Percocet dated the same day as a procedure for Patient C. However, this prescription was not recorded anywhere in the Hallmark Health records as being related to the patient's medical treatment. Nor was there anything in the

records for this procedure indicating that Dr. Taylor had any authorized role in Patient C's treatment.

62. On June 30, 2004 I received copies of actual prescriptions written by Dr. Taylor from Investigator Spinale of the Massachusetts Board of Registration in Medicine. These had been subpoenaed from Walgreen's in an effort to locate any and all prescriptions written by Respondent Taylor for Patients B and C. One such prescription was written 10/18/2002 on a Hallmark Health prescription pad for Patient B. This was for 30 Percocet and bearing a signature of Stephanie Taylor, M.D. Respondent's DEA number is also present on the prescription. This prescription predated Patient B's first visit to Dr. Butler which was 11/01/2002 according to the record.

63. In this package from Massachusetts I found prescriptions for Nifedepine 10 mg., (a Beta Blocker), and Celebrex 200 mg. for Patient C. These were phoned-in prescriptions under the name of S. Taylor. The date was 2/02/2003 and these prescriptions did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

64. In this package from Massachusetts I also found a prescription for Ultracet, 60 tablets, (a prescription pain reliever), for Patient C. This was a phoned-in prescription under the name of S. Taylor. The date was 2/07/2003. This prescription correlated by date to a Gastorendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford, MA. by Dr. Michaelson. However there was no mention in that hospital chart indicating that Dr. Taylor prescribed this medication or that she had any authorized role in Patient C's treatment.

65. In this package from Massachusetts I also found a prescription for Vicodin, (Hydrocodone w/APAP). This was a written prescription on a Hallmark Health Family Center prescription form dated 2/19/2003 to Patient C. This bore a signature in the name of Stephanie Taylor, M.D. This prescription was one that I had questioned Respondent Taylor about. Respondent "did not recall writing" the prescription. This prescription did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

66. In this package from Massachusetts I also found a prescription for Tussionex. This was a written prescription on a Hallmark Health Family Center prescription form dated 02/20/2003 to Patient C. This was bearing a signature which looked like the signature of Stephanie Taylor, MD. This prescription was one that I had questioned Respondent Taylor about when I had simply a computer generated report from Walgreen's. It was one that respondent "did not recall writing". This prescription did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

67. In this package from Massachusetts I also found a prescription for Oxycodone w/APAP, (Percocet). This was a written prescription on a Hallmark Health Family Center prescription form dated 3/25/2003 for Patient C. The prescription bore a signature in the name of Stephanie Taylor, MD. This prescription was one that I had questioned Respondent Taylor about during my interview with her. It was one that respondent "did not recall writing". This prescription did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

68. In this package from Massachusetts I also found prescriptions for Oxycodone w/APAP, (Percocet) and Metoclopramide. These were written prescriptions on Hallmark Health Family Center prescription forms dated 4/07/2003 to Patient C. These bore the signature of Stephanie Taylor, MD. These prescriptions were ones that I had questioned Respondent Taylor about previously. These were prescriptions that respondent also "did not recall writing" or claimed to have written under someone else's direction at Tufts according to Respondent Taylor. These prescriptions did correlate by date to a Gastorendoscopy with Dilation procedure performed at Lawrence Memorial Hospital in Medford by Dr. Michaelson. However there was no mention of these prescriptions being ordered according to the complete records I have from Hallmark Health. Nor do the records indicate that Respondent had any authorized role in the treatment of Patient C.

69. In this package from Massachusetts I also found a prescription for Tramadol 50 mg., (a pain reliever). This was ordered for Patient C by Respondent. The date was 6/10/2003. This prescription did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

70. In this package from Massachusetts I found another prescription for Tramadol 50 mg., (a pain reliever) ordered for Patient C by Respondent. The date was 6/25/2003 and authorized 2 refills. This prescription did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health. I noted as well that the prior Tramadol prescription for 80 tablets should have lasted until 6/30/2003. I believe this prescription was 5 days early if the patient, in fact, had followed the prescribed course.

71. In this package from Massachusetts I also found prescriptions for Zocor and Allegra for Patient C. These were phoned-in in prescriptions under the name of S. Taylor. The date was 6/10/2003 and these prescriptions did not correlate to any of the treatments provided to Patient C according to the complete records I have from Hallmark Health.

72. In summary, I believe the above facts show that Respondent Taylor engaged in a pattern of prescribing and treating an individual to whom she was formerly related by marriage, a social friend and a person with whom she was intimately involved. I believe this pattern also shows that Respondent prescribed medication for a member of her family. Such prescribing by Respondent appears to have been in direct contradiction to her restrictive practice agreements with the Vermont Board of Medical Practice. I also submit this affidavit as information appearing to indicate that Respondent practiced medicine in Vermont at a time when her license was lapsed in Vermont and therefore invalid. Under Board rules and Vermont law, this appears to constitute the illegal practice of medicine.

Dated at Burlington, Vermont this 3rd day of September 2004.

PHILIP J. CIOTTI
Investigator, Vermont Board of Medical Practice

SUBSCRIBED AND SWORN TO BEFORE ME:
at Montpelier at Vermont
Bonnie L. Boardman
NOTARY PUBLIC

My Commission Expires 2/10/07

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